New Jersey Department of Health and Senior Services
Division of Aging and Community Services
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www.aging.nj.gov

GLOBAL OPTIONS FOR LONG-TERM CARE (GO) MEDICAID WAIVER PROGRAM

PARTICIPANT HANDBOOK

My Care Management Agency:

_____

My Care Manager's Name:

_____

Telephone Number:

_____

Welcome to the Global Options Program!

This Handbook provides an overview of the Global Options program and the rights and responsibilities of participating. It is important for you to understand the eligibility requirements, the services, the providers, and also the limitations of this program so you can make informed decisions about your care.

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GLOBAL OPTIONS FOR LONG-TERM CARE

What is the Global Options program?

The Department of Health and Senior Services' Division of Aging and Community Services operates the **Global Options for Long-Term Care** (GO) Medicaid Waiver program. This program is specifically for older adults age 65+, or persons with physical disabilities between ages 21-64, who can receive home and community-based services instead of living in a nursing home.

GO participants work with a Care Manager to create a personalized Plan of Care based on their assessed care needs. GO participants have the option to hire and direct their own service providers (See Page12). Once the Plan of Care is approved, the Care Manager will arrange service providers and contact the participants monthly to ensure that their services continue to meet their care needs.

The NJ State Department of Health and Senior Services is committed to providing quality home and community-based services that promote independence, dignity, and choice. The State recognizes that many people:

- Want to remain in their homes as they get older;
- Need some help with everyday tasks to remain on their own;
- Can't afford to pay privately for this assistance; and
- Get most of their help from family, friends, and neighbors.

We refer to help from family, friends, and neighbors as "informal support." Global Options for Long Term Care is NOT intended to replace this valuable assistance but to strengthen it by offering some support to fill the gaps that cannot be met by your family and friends. By offering a flexible package of services, based on the participants assessed needs, GO strengthens the ability of caregivers to continue in their critical role as the main support providers.

As with any program, there are limits to what is available and permitted. Service agencies must be approved by Medicaid and some agencies may not be available in your area. The State sets the rates that agencies are paid and the individual cost cap that participants cannot exceed, and prior authorization for certain services may be required. Payments are made on a fee-for-service basis and paid directly to service agencies. Money is NOT distributed to participants or caregivers under any circumstances. It is also important to understand that in all cases, Medicaid is considered the payer of last resort.

ELIGIBILITY CRITERIA

GO participants must meet all of the following criteria:

- Be a resident of New Jersey.
- Be 65 years old or older, or is between the ages of 21-64 and determined physically disabled by the Social Security Administration or by the Disability Review Section of the Division of Medical Assistance and Health Services.
- Qualify for Medicaid financial eligibility by:
  - Qualifying for SSI in the community, or
  - Qualifying for Medicaid Only- Institutional Level, or
  - Qualifying for New Jersey Care (with income at or below 100% of the federal Poverty Level and resources at or below $4,000).
- Meet Clinical eligibility, which is determined by a State or county professional as needing Nursing Facility Level of Care.
- Reside in an approved community living arrangement.
- Want to enroll and receive Waiver services rather than live in a nursing home.

Individuals not eligible for GO:

- Individuals between the ages of 21 and 64 who are chronically mentally ill, intellectually disabled* or developmentally disabled are ineligible for Global Options for Long-Term Care enrollment.

Once enrolled, participants may remain on Global Options as long as they choose, provided they remain eligible, abide by program rules, and their needs and general health and welfare can be addressed by the program.

At any time, if a GO participant no longer meets these eligibility and enrollment criteria, he or she may be terminated from the program due to ineligibility. Please see page 14 for reasons for program disenrollment.

**The U.S. Centers for Medicare and Medicaid Services, with reference to 42 Code of Federal Regulations 441.301(b)(6) uses the term mental retardation as opposed to intellectual disability.*

SERVICES

What services are permitted in GO?

The following services may be available to you when assessed as a need and identified in your Plan of Care.

GO **Waiver services** may include:

- Assisted Living/Adult Family Care
- Attendant Care *****
- Caregiver Participant Training
- Care Management
- Chore Services
- Community Transition Services *****
- Environmental Accessibility Adaptations *****
- Home-Based Supportive Care (HBSC)
- Home Delivered Meal Services
- Personal Emergency Response Systems
- Respite *****
- Special Medical Equipment and Supplies *****
- Social Adult Day Care
- Transitional Care Management
- Transportation

GO participants must need and receive at least two Waiver services monthly, one of which is the service of care management.

GO participants also have available New Jersey Title XIX Medicaid **State Plan Services**, which may include:

- Adult Day Health*****
- Advanced Practice Nurse
- Chiropractic
- Clinic
- Dental
- Hearing Aid
- Home Health
- Hospital
- Hospital Outpatient
- Laboratory
- Medical Supplies & Equipment*
- Nursing facility
- Optometric
- Optical Appliances
- Personal Care Assistant*****(PCA)
- Pharmaceutical
- Physician
- Podiatric
- Prosthetic and Orthotic Devices
- Rehabilitation Therapies
- Transportation*****

*******Requires prior authorization*

Service Definitions and Limitations

Your Care Manager can provide a detailed description of each Waiver service for you. In addition, your Care Manager will explain that there are limits on the amount, frequency, and length of time of each service. Before services can begin, Care Managers must approve and arrange services for GO participants.

The services of Personal Care Assistant (PCA) and Home-Based Supportive Care (HBSC) are mutually exclusive of one another. That means that a participant must choose either PCA or HBSC, but cannot receive both.

All GO services are subject to limitations, so ask your Care Manager for more information on specific restrictions. Here is a list of important limitations that apply to all GO services:

- Services are to be cost-effective, while supporting your care needs.
- Services are designed to supplement, not replace, the assistance already being provided by family, friends and neighbors.
- Services are for the GO participant, NOT other household members.
- Services are requested according to the Plan of Care but cannot be guaranteed.
- GO cannot be used to pay for what currently is being paid privately or through another program.
- GO Waiver services are not available while an individual is an inpatient of a hospital or nursing home for an acute medical stay.

Who provides these Services?

Services, as authorized and arranged by your Care Manager, may only be given by approved agencies.

Services can be provided by traditional Medicaid community agencies, qualified Non-traditional entities, or qualified Participant-Employed Providers (individuals hired by the participant). All service providers must meet qualification requirements determined by the State of New Jersey and approved by the federal government.

RIGHTS AND RESPONSIBILITIES

To successfully participate in GO you must understand and accept your various rights and responsibilities.

Participant Rights

You have the right to:

- Be treated with dignity and respect.
- Make informed decisions based on accurate and timely information.
- Choose someone you trust to represent and make choices on your behalf.
- Feel safe and secure with your life, including your health and well being;
- Be free from exploitation, fraud and abuse.
- Refuse service.
- Choose among all willing and qualified service agencies.
- Be notified of program changes in a timely manner.
- Be assured of privacy and confidentiality.
- Withdraw voluntarily from the program at any time.
- Ask questions until you understand.
- Request a re-evaluation if your needs change.
- Voice grievances about care or treatment without fear of discrimination or reprisal.
- Request a Fair Hearing and follow the Appeal Process as defined by the NJ Department of Human Services' Division of Medical Assistance and Health Services.

Participant Responsibilities

Along with rights come responsibilities. Here are some of your key responsibilities:

- Participate fully in your assessment.
- Work with your Care Manager to prepare a Plan of Care.
- Actively participate in regular contacts (via telephone calls and home visits) by your Care Manager.
- Report changes in your care needs and health status to your Care Manager and providers of services. Tell them when you need more or less help, or if you have been admitted to a hospital or nursing home.
- Provide complete and accurate information.
- Sign the appropriate Consent for Release of Information form so the care management agency and providers can obtain and/or release necessary records and information regarding your care and eligibility.
- Tell your Care Manager and local County Welfare Agency, and provide verification as requested, when you have a change in your income, resources, medical expenses, insurance premiums or coverage.
- Tell your Care Manager immediately if you relocate.

- Tell your Care Manager and other service agencies if you are not able to keep your appointments, or if you will be away or out of the state for a prolonged amount of time (i.e. two weeks).
- If you are unhappy with your services, tell your Care Manager or service agencies.
- Understand that GO does not provide 24-hour/7-day a week coverage and that you will need to work with family and friends to safeguard against potential risks.
- Develop an Emergency Back-Up Plan for care and services with your Care Manager as services are not guaranteed.
- Pay your Room and Board in an Assisted Living facility and your Cost Share on time each month (if applicable).
- Treat service workers with dignity and respect.
- Keep all GO documents, such this Participant Handbook, for your personal records and future reference.
    - You need to approve several documents and sign your name as terms of participation, including but not limited to:
        - The **Choice of Care** form,
        - The **Consent for Release of Information** form,
        - The **Agreement of Understanding** form, and
        - The **Plan of Care.**

CARE MANAGEMENT

What does a Care Manager do?

A Care Manager is a person who is experienced in working with older adults and adults with physical disabilities. Every Global Options participant must receive Care Management as a Waiver service.

Care Managers will help GO participants by:

- Continually reassessing their care needs for Waiver services;
- Developing and reviewing the Plan of Care;
- Authorizing services;
- Coordinating services and providers;
- Making sure that services are delivered according to the Plan of Care;
- Monitoring participants general health and welfare through regular contacts and home visits;
- Monitoring the participant's individual cost cap; and
- Determining the cost share of Assisted Living/Adult Family Care participants.

Care management does not include the provision of direct services to the GO participant for tasks that are normally covered as other distinct services, such as transportation, hands-on medical care, private social work or therapeutic counseling.

The name and telephone number of your Care Manager is listed on the front and back of this Handbook so it is easy to find when you need it.

PLAN OF CARE

What is a Plan of Care?

The Plan of Care is based on your assessed care needs and it outlines what services and supports are necessary to help you. Each Plan of Care is individualized for every GO participant.

The standard Plan of Care form and the required tools and methods used to support and develop it, promote a consistent manner for a comprehensive and cost-effective delivery of services for GO participants statewide. The Plan of Care is reviewed continually, and updated at least annually, to ensure that each participant is getting the appropriate services that he or she needs.

Signatures on the Plan of Care

All Plans of Care are to include at least three signatures (Participant, Care Manager and Care Management Supervisor), and any others as applicable. Copies are to be made available to everyone who signed. If you have a representative, that person may sign for you.

On the Plan, you are asked if you Agree or Disagree with the following:

- I agree with this Plan of Care.
- I had the freedom to choose the services in this Plan of Care.
- I had the freedom to choose among available service agencies.
- I helped develop this Plan of Care.
- I am aware of my rights and responsibilities as a participant.
- I am aware that these services are not guaranteed.
- I've been advised, understand, and accept the potential risk factors.

If you disagree with any of the above-mentioned statements, an explanation of your concerns is to be provided on the Plan prior to your signing it.

The Care Manager will also explain, and periodically remind you, that specific clinical and financial criteria are required to participate in this program and who is responsible for re-determining continued eligibility for both.

COMPLAINTS AND APPEALS

What do I do if I am unhappy with my services?

If you are not satisfied with your services, call your Care Manager right away. Your Care Manager will talk with you and help you determine how things might be made better. Care Managers will work with you and your service agencies to try and fix the problem. At times, you may decide it is appropriate to contact the Care Management Supervisor.

Fair Hearing

As a Medicaid beneficiary you are given the opportunity for an in-person Fair Hearing. This is a formal type of appeal to a decision or action with which you don't agree. The Office of Administrative Law is the State agency in New Jersey that provides an independent hearing. An administrative law judge hears the case, in court, and writes the initial decision.

As a GO participant, you have the right to request a Medicaid Fair Hearing under the following circumstances:

1. if you are determined ineligible for continued enrollment in the program,
2. if you are denied the Waiver services or providers of your choice, or
3. if your Waiver services are suspended, reduced or terminated.

Once you are given a written Notice, you must request a Fair Hearing within 20 days of the date of the letter. If you have been receiving Medicaid benefits and request a Fair Hearing within the 20-day period, your Medicaid benefits may continue until a hearing decision is reached. However, if the Fair Hearing decision is not in your favor, you may be required to repay the cost of any Medicaid benefits you were not entitled to receive.

Adult Protective Services

Professionals, including Care Managers are required to report suspected abuse, neglect or exploitation of any vulnerable adult over the age of 18 who resides in a community setting.

In New Jersey, there is an Adult Protective Services (APS) program in each of the 21 counties. Calls may be made to those particular County APS offices, or to the Public Awareness, Information, Assistance & Outreach Unit at: **1-800-792-8820.**

If you believe you are the subject of abuse, neglect or exploitation, report it to APS immediately. You may also contact your Care Manager for assistance on your behalf.

Facility-Based Complaints and Investigation

- NJ Office of the Ombudsman for the Institutionalized Elderly

The Office of the Ombudsman for the Institutionalized Elderly investigates claims of abuse and neglect of people, age **60 and older**, living in **nursing homes** and other long-term healthcare facilities such as **assisted living facilities**.

To file a complaint:

Call 24-Hour Toll-Free Hotline: 1-877-582-6995

Email: ombudsman@advocate.state.nj.us

Write: The Office of the Ombudsman
PO Box 852
Trenton, NJ 08625-0852

Fax: 609-943-3479

- NJ Division of Health Facilities and Evaluation

This Division investigates all complaints against **health care facilities**. Their 24-hour hotline handles consumer complaints and facility emergencies seven days a week. Patients, health care facility employees and other members of the public may file complaints about hospitals, ambulatory surgery centers, home health agencies, nursing homes, assisted living residences, comprehensive personal care homes, adult medical day care, and other licensed acute- and long-term care facilities.

To file a complaint:

Call 24-Hour Toll-Free Hotline: 1-800-792-9770

New Jersey Department of Health and Senior Services
Division of Health Facilities Evaluation and Licensing
PO Box 367
Trenton, NJ 08625-0367

PARTICIPANT-DIRECTED CARE

What does Participant-Directed Care mean?

Global Options was designed to provide the greatest possible responsibility and independence to participants so they have more control over making decisions, planning, and managing their care.

For those participants who are capable of and choose to direct their own care, there are several possibilities. Specific opportunities to direct your own services include managing your own state-authorized budget and/or hiring your own, state-approved employees, possibly even your friends or family.

Participant-Directed Care also means that you, with the help of your Care Manager, will:

- Determine what services you need,
- Select who will provide them,
- Determine when and how they should be delivered, and
- Make sure services are provided as listed in the Plan of Care.

For more specific information, please contact your Care Manager.

COSTS

Is there a Cost for GO services?

There is no cost to the participant for GO services except for the Assisted Living or Adult Family Care services. For those services, a person is always responsible to pay Room and Board fees. GO participants who live in an Assisted Living facility or Adult Family Care home are expected to contribute to the cost of their services. This is called a "Cost-Share". The amount of your Cost Share depends on your income.

Cost Share liability will be explained to you as part of the Options Counseling information you need to consider when applying for GO services. Once you are enrolled in GO, you will work with your Care Manager to complete a Cost Share Worksheet as part of the care planning process.

Completing a Cost Share Worksheet involves these steps:

1. Listing your income from all sources.
2. Subtracting Allowable Deductions* such as the cost permitted to cover medical insurance premiums.
3. Using the remainder to determine how much you will pay as your Cost Share.
4. Providing supporting documentation, such as receipts and prescriptions, in a timely manner.
5. Understanding how and to whom you will pay this Cost Share.

**For information on Allowable Deductions please contact your Care Manager.*

Note: There are a number of items that are not permissible deductions when your Cost Share is being calculated, such as:

- Money due to the Assisted Living facility from the participant for debts incurred prior to GO Waiver enrollment
- Cable television or internet connection and services for the participant
- Food costs other than those included as part the facility's Room and Board payment.
- Physician, dental and other health related bills from practices that don't accept Medicaid.

You will always receive a copy of your Cost Share Worksheet. The Worksheet is reviewed with you every six months and a new one is done annually. It can be updated if you have major changes in your income or deductions. You must report any changes to your Care Manager.

DISENROLLMENT

How long can a participant stay on GO?

GO is voluntary, you may stay with the program as long as you choose, provided you are eligible, follow the program rules, and your needs can be served by the program.

Voluntary Withdrawal

You may voluntarily withdraw from GO at any time. This can be done by contacting your Care Manager, who will assist you in completing a Participant Withdrawal form to disenroll.

Disenrollment Criteria:

There are other reasons disenrollment can occur, including:

- You no longer meet financial or clinical eligibility criteria.
- You will not allow the Department of Health and Senior Services staff or its designee to complete the clinical eligibility assessment.
- You relocate to an unapproved licensed residence/setting.
- You move out of New Jersey.
- You choose to receive Medicare/Medicaid Hospice in a nursing home.
- You were transferred/enrolled into another Medicaid Waiver or in the State's Program of All Inclusive Care for the Elderly (PACE).
- You refuse to pay your Room and Board and/or Cost Share.
- You no longer need the services offered in the GO program.
- You have not received services and/or can not be contacted or located at the last known address for two months.
- You refuse services, including care management; or are not receiving the required two Waiver services and you refuse to withdraw.
- The amount/cost of services required to be adequately cared for exceeds the scope/limits established by the GO program.
- You fail to act in accordance with the rules governing involvement in the program.

All disenrolled individuals are helped as much as possible to secure alternate arrangements. In any such event, you would be informed of the reason and of any rights you may have to appeal the disenrollment determination.

MEDICARE AND MEDICAID

What is Medicare?

Medicare is a federal health insurance program for people age 65 or older, under age 65 with certain disabilities, and any age with permanent kidney failure. You must have entered the United States lawfully and have lived here for 5 years to be eligible for Medicare. Beneficiaries pay part of their health care costs through deductibles for hospital and other services. Small monthly premiums are required for non-hospital coverage. It is basically the same everywhere in the United States and is run by the federal Centers for Medicare and Medicaid Services (CMS).

What is Medicaid?

Medicaid is also a health insurance program, however, it's a federal and state assistance program available only to certain people who have limited income and resources. It varies from state to state. In NJ, the Medicaid program is called the Medicaid 'State Plan'. It is administered by the NJ Department of Human Services' Division of Medical Assistance and Health Services. This Department strives to ensure that all of New Jersey's residents have access to affordable, quality health care through its Medicaid program. There is an array of 'State Plan' services available through Medicaid. For example, it pays for hospital, doctor, medicine, or nursing facility care.

People on Medicare who are very low income can have coverage from both Medicare and Medicaid. The Medicare and Medicaid ID cards should be shown together when getting any medical services.

What is a Medicaid Waiver?

A 'Medicaid Waiver' program is different than the Medicaid 'State Plan' program. CMS gives states the opportunity to design special programs that offer select Home and Community-Based Services (HCBS), as alternatives to institutional (nursing home) care. These special programs are called Medicaid Waivers. There are important federal laws, through Section 1915 of the Social Security Act, which set standards for operating these programs.

The several Medicaid Waivers approved in New Jersey and administered by the Division of Medical Assistance and Health Services, include:

- Community Resources for Persons with Disabilities Waiver
- AIDS Community Care Alternatives Program Waiver
- The Traumatic Brain Injury Waiver
- Community Care Waiver
- Global Options for Long-Term Care Waiver.

MEDICAID FRAUD

What is Medicaid Fraud?

Medicaid fraud is when a Medicaid beneficiary (GO participant), a service provider or an employee is untruthful regarding Medicaid services provided, in order to obtain improper services or payments. It is also considered fraud when an individual knowingly gives false, incorrect, incomplete, or misleading information in order to qualify for Medicaid coverage.

The Medicaid Fraud Division in the Office of the State Comptroller was created to improve and preserve the integrity of the Medicaid program and conducts investigations and coordinates efforts to control such activities.

Some examples of Medicaid fraud include, submitting timesheets for services not actually given or for services provided by an unapproved agency or individual; misrepresenting ones needs; or not telling Medicaid about ones own assets.

NOTE: Suspected cases of fraud will be reported and may be referred to the local police authorities for further investigation and possible prosecution.

If you suspect Medicaid Fraud, contact the
Medicaid Fraud Division at
P.O. Box 025
Trenton, NJ 08625-0025
or at 609-826-4700.

Important Contact Information

My Medicaid ID#: _____

My Address:

Telephone #: _____

My GO Care Manager: _____

Telephone #: _____

My Doctor: _____

Telephone #: _____

In an Emergency, call: _____

He/she is my: _____

Telephone #: _____

My Service Providers

Service: _____

Provider: _____

Telephone #: _____

Service: _____

Provider: _____

Telephone #: _____

Service: _____

Provider: _____

Telephone #: _____

Service: _____

Provider: _____

Telephone #: _____